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AUTHOR Sadoff, Wallace L.; Crandall, Arlene B.
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ABSTRACT

In response to the recent suicide epidemic, many school districts have struggled to devise suicide prevention procedures. Smithtown Central School District in St. James, New York developed procedures in 1983 using research data on the warning signs and risk factors relating to the suicidal child. These procedures focus on a multidisciplinary team approach to suicide prevention. By involving all the professionals in the school setting, these procedures combat the suicidal impulse at its most basic level. The implementation of the procedures establishes a network of support for the suicidal child, thereby alleviating the overwhelming feeling of isolation. This network of support is extended into the community through parent involvement; presentation to local civic groups; and direct contact with hospitals, clinics, and private practitioners. This paper examines the warning signs and risk factors associated with a suicidal child and describes the Smithtown approach to suicide prevention. Low, medium, and high risk case studies are included to illustrate the multidisciplinary team members' involvement at each stage of the crisis. (Author/NB)

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A Multidisciplinary Team Suicide Prevention Program

Wallace L. Sadoff and Arlene B. Crandall

Smithtown Central School District

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Abstract

In response to the recent suicide epidemic many school districts have struggled to devise suicide prevention procedures. Smithtown Central School District developed procedures in 1[illegible]3 utilizing research data on the warning signs and risk factors relating to the suicidal child. These procedures focus on a multidisciplinary team approach to suicide prevention. By involving all the professionals in the school setting these procedures combat the suicidal impulse at its most basic level. The implementaion of the procedures establishes a network of support for the suicidal child, thereby alleviating the overwhelming feeling of isolation. This network of support is extended into the community through parent involvement, presentation to local civic groups, and direct contact with hospitals, clinics, and private practioners. The case studies that are included illustrate the multidisciplinary team members' involvement at each stage of the unfolding crisis.

The suicide rate among children and adolescents has skyrocketed in recent years. Anderson has reported a 131% increase in the 15 -24 year old age group between 1961 and 1975 (Wells & Stuart,1981). In 1979 the alarming figure of a 300% increase for this age group since 1950 was cited by the Bureau of Vital Statistics (Davis, 1985). Pfeffer has updated these figures in her recent publication, The Suicidal Child, indicating the ongoing critical suicide rate of 5,000 teenagers a year (1986). As a result of this documented increase in suicidal behavior many schol districts have begun to seek out ways of dealing with this crisis.

Before dealing with this crisis in the schools, a system for identification of the at risk population must be established. Most research on suicidal behavior in children cite warning signals and risk factors which can be used for this purpose. Primary warning signals include: 1) sudden change in behavior or personality including sleep, eating habits, school performance, 2) self-destructive life style, 3) accident proneness, 4) withdrawal, 5) recent major loss, 6) social isolation, 7) depression, 8) relief after a depression, 9) giving away possessions, 10) verbalizations of a death wish, 11) a suicide plan (Children Under Pressure, 1985). Any child demonstrating one or more of these signs could be considered at risk for suicide.

Risk factors most commonly cited include previous suicidal behavior, family suicidal behavior, parental abuse,unrealistic expectations from self/parents, parental absence, drug and alcohol abuse, and anti-social behavior (Pfeffer, 1986; Wellman,1984). Risk factors have also been described in a developmental perspective. Anderson (Wells and Stuart, 1981) identifies three stages leading to the suicidal act: 1) history of family and

social instability, 2) acute behavioral changes and an increase in problems with the onset of adolescence, 3) total breakdown of interpersonal relationships or failure experiences. Knowledge of risk factors provides a framework for the interviewer to utilize when confronting a possible suicide crisis.

Smithtown Central School District began developing a suicide prevention program in the spring of 1983 by adapting this information of warning signs and risk factors into viable procedures. The precipitating factor for this development was the concern raised by the well publicized Westchester County copy-cat/cluster suicides. Initial steps in development included consultation with districts in the Westchester area, gathering and reviewing information from the American Suicidology Association, and consultation with Suffolk County Office of Mental Health.

Both community and school groups worked together utilizing these materials to produce an initial draft of prevention/identification procedures which would be functional within the structure of the Smithtown district.

Several groups of people then became simultaneously involved in the process. Community meetings were arranged through the P.T.A. to provide information and awareness that suicide prevention procedures were being developed within the district. A draft outline of the program was sent out to all support staff (school psychologists, social workers, guidance counselors, nurses) and district administrators to elicit comments and suggestions. These comments and suggestions were incorporated into the draft outline to form the final version of the district procedures.

The final version of the procedures was distributed to all support staff.

A local suicide hotline supplied trained personnel to review crisis interviewing techniques with the support staff . Support staff then made presentations at faculty meetings in individual buildings. In addition, district-wide workshops were offered to all district personnel. Periodic community presentations were made to inform as many parents as possible. In this way the schools became the focal point for the implementation of a unified school/community prevention program.

THE PROGRAM

The Smithtown procedures are implemented by the multidisciplinary team in each school. The training of all support staff members has created a wide network within which referrals can be made. Any parent, student, or staff member can contact a support staff member when a student exhibits any of the warning signs. The student is then interviewed by the team member who is the most familiar with the student. This team member elicits information from the student and with the framework of knowledge based on risk factors learned in training, he/she determines the level of risk. Once a level of risk has been determined, parents are contacted. Even a low risk case will include parent contact to ensure both home and school awareness of the student's emotional state. If a student is at a meduim level of risk, private counseling is usually recommended. High risk identification most often involves a psychiatric evaluation referral or immediate hospitalization. All recommendations are followed up with further parent contact to encourage appropriate support and communication between parents, therapists, and school after the crisis has passed. The dissemination of information and

communication between team members is depicted in Figure 1.

A specialized school program, unique to the individual student, can be created because of the involvement of staff members from all disciplines. In this way students experiencing crisis can continue their education in a supportive environment rather than seeking alternative placements.

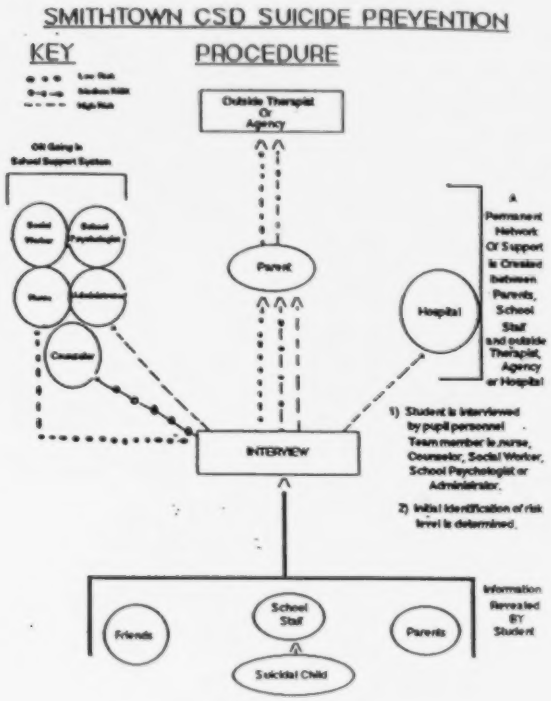
SMITHTOWN CSD SUICIDE PREVENTION
KEY
PROCEDURE
Outside Therapist Or Agency
Parent
Hospital
A Permanent Network Of Support Is Created between Parents, School Staff and outside Therapist, Agency or Hospital
INTERVIEW
1) Student is interviewed by pupil personnel Team member ie nurse, Counselor, Social Worker, School Psychologist or Administrator.
2) Initial identification of risk level is determined.
Friends
School Staff
Parents
Suicidal Child
Information Revealed BY Student

Figure 1

CASE STUDIES

The following cases are used to demonstrate the procedures and interaction between the pupil personnel team members, parents and outside clinical support when dealing with a suicidal child.

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Low Risk Case Study

Cathy came to our attention through the concern voiced by her English teacher. Mrs. Brown had spoken to Cathy's guidance counselor regarding an essay that Cathy had written. It described a character who was expressing feelings of hopelessness. The counselor followed up the teacher's concern by contacting the student and exploring these feelings.

In the initial interview the student resisted any identification with the character in the essay. Cathy denied that there was any problem in her life. Periodically she interjected the phrase "I don't care" in relation to school, friends, and her parents reactions to her.

As she began to use this phrase repeatedly, the counselor confronted her with the statement, "Of course you want people to care." This confrontation of Cathy's denial of her emotional needs created an emotional release evidenced by her beginning to cry. This created the opportunity for Cathy to explore feelings she had been denying. Once she was able to put words to her feelings, Cathy's emotionality subsided. At this point Cathy found it easier to talk about the many situations in her life which demonstrated the strength of her coping mechanisms. The counselor suggested a follow up appointment.

During the second session the discussion focused on Cathy's primary relationships. The school counselor suggested that it would be important for people close to Cathy to be aware of the emotional conflicts she was experiencing. Initially Cathy resisted this suggestion. The school counselor then focused on the reason Cathy's parents needed to be informed of these conflicts. Cathy began to sense her need for adult support and concurred with the decision to set up a meeting with her parents. A parent appointment was

set up for the following day. That afternoon the school counselor spoke to the administration and reviewed the case with the school psychologist.

At the parent meeting the school counselor shared his concerns and described Cathy's current emotional status with her parents. He suggested ways of opening the lines of communication at home and requested that they keep touch with him regarding her emotional state. He explained to them that these feelings of hopelessness could develop into more serious concerns such as suicide. The counselor provided her parents with the local suicide hot line number and clinic referrals in case they became further concerned about Cathy's status and were unable to get in touch with the school.

The next day the school counselor introduced Cathy to the school psychologist so she would be aware of another contact person within the building.

Medium Risk Case Study

Julie's parents contacted the school counselor due to her poor grades. When the counselor met with Julie, she appeared quite anxious and emotional as demonstrated by her speech pattern and her body language. These observations were consistant with those made over the past year by the counselor. During the interview Julie began to verbalize her feelings . She stated that she had no one who would listen to her at home; there was a great deal of pressure coming from her parents to achieve at a level that she felt was unrealistic for her; and that she was continually criticised for her ideas regarding her career and personal goals. During the second session Julie agreed that a parent conference would be helpful. An appointment was made for the next day.

Due to his concern that Julie's emotional state appeared to be more agitated than in the past, the counselor notified the pupil personnel team of this case.

In past conferences with Julie's parents there had been a strong denial of the genuineness of her emotionality. In order to emphasize the critical nature of Julie's present emotional state, both the counselor and school psychologist were present for this meeting. As expected, the parents brought support to demonstrate that Julie's school problems were educational in nature rather than emotional. Accompanying her parents was a special education teacher who had tested Julie and contended that Julie was learning disabled. A lengthy meeting resulted in the following:

1. The parents insisted that Julie be evaluated for learning disabilities.
2. The parents reluctantly agreed to pursue outside therapy for Julie.
3. The parents revealed that Julie had attempted suicide four months ago.

Initial contact with a therapist was not supported by the parents, i.e. continual difficulty making appointments and arranging transportation; therefore Julie sabotaged this therapy by becoming resistant. The psychological evaluation done by the school psychologist revealed severe emotional conflict and no learning problem. Because her parents did not pursue therapy after a second recommendation from the school, Julie relied on inside school support for the following year. In the fall of the next year Julie's mother agreed to contact the school recommended therapist subsequent to the total breakdown of the martial relationship. In-school support contacts continued with special services personnel. In order to create a continuity of support the school continues to maintain close contact with

Julie's parents and her therapist.

High Risk Case Study

Brenda was being seen by the school counselor regarding academic pressures from home. Brenda was beginning to question her ability to deal with these pressures from home as well as the pressures from within herself. She began to exhibit unusually anxious behaviors, e.g. rubbing her hands together, darting glances, rapid speech accompanied by stream of consciousness thought patterns. The school counselor felt it would be advisable for Brenda to meet the school psychologist. Brenda was agreeable to this. Even before the appointment could be made, Brenda appeared at the school psychologist's office. Her anxiety level seemed to be overpowering her coping mechanisms. This interview also revealed that Brenda was seriously considering suicide as a method of escaping her anxiety.

The school psychologist contacted the school counselor regarding Brenda's present state. At this time Brenda's parents were contacted at work and asked to come to school. Her parents were immediately contacted because of Brenda's inability to continue in the school environment. She expressed fear of going to class, seeing her friends, or being able to control her suicidal intentions.

When Brenda's parents arrived, the administrator, counselor, and school psychologist met with them to explain the present situation. The parents realized the severity of the situation and were agreeable to the school's recommendations. They were immediately put in touch with a therapist.

Brenda continued to attend school for several weeks while school

personnel maintained contact with the therapist. One day she came to the school psychologist because she felt overwhelmed by feelings of fear and power. She expressed the feeling that she was responsible for bringing peace between the USA and USSR. Brenda thought she might be a messenger who would go to the top of a mountain, proclaim her message and then jump off. The school psychologist immediately contacted the counselor who apprised other team members while the psychologist remained with Brenda.

The school psychologist remained with the student while the others contacted parents, therapist, and local hospital. When the parents arrived the social worker met with them to explain the need for hospitalization. He then advised them of the availability of space in various psychiatric units. He discussed insurance needs, transportation and admission procedures. The parents reached a decision and took Brenda directly to the hospital. Brenda was hospitalized for two months. When her release was imminent, her parents contacted the school. With the input of clinical staff at the hospital and Brenda's therapist, a severely modified program was devised for her reentry to school. Over the next three months the school team consulted with Brenda's therapist and the psychiatrist in order to continually readjust her program until she was ready to carry a full schedule.

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